Healthy Families Program
Cultural and Linguistic Group Needs Assessment Report

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Lesley Cummings, Executive Director
Managed Risk Medical Insurance Board

Lorraine Brown, Deputy Director
Benefits and Quality Monitoring Division

Vallita Lewis, Manager
Program Development and Evaluation Unit

Prepared by
Nora Nario, RN, BSN
Program Research Analyst

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The demographic profile of the Healthy Families Program (HFP) reflects the rich diversity that exists in California. Recent estimates from the 2001 California Health Interview Survey indicate that the race/ethnic makeup of children eligible for the HFP are as follows: 66 percent Latino, 21 percent White, 7 percent Asian/Pacific Islander, 2 percent African American, 1 percent Native American/Alaska Native and 3 percent multiple races. According to current enrollment data, the ethnic distribution in the HFP is similar to these estimates. Sixty-seven percent of current enrollees are Latino, 16 percent are White, 13 percent are Asian/Pacific Islander, 3 percent are African American and less than 1 percent are American Indian/Alaska Native.

In addition to the ethnic diversity, there are many language groups represented among HFP applicants and subscribers. Of the primary languages recorded on the program applications, 50 percent of applicants indicate English as their primary language, 41 percent indicate Spanish, 3 percent indicate Chinese and approximately 3 percent indicate Vietnamese and Korean. Other languages constitute less than 3 percent of the total applicants.

A key factor in successfully providing access to comprehensive, quality health care coverage through the HFP is the ability of participating plans to address the needs of this diverse population. The ability of providers to communicate with subscribers and their parents is only one part of the equation. Health care providers and participating plans must be able to address the incidence of disease among their HFP patients and the efficacy of medical treatments for this population. Participating providers and plans must also recognize that subscribers from various ethnic groups may have distinct patterns of health beliefs, values, and behaviors, all of which can significantly affect the level of compliance with prescribed treatment.

The HFP health, dental and vision plan contracts include specific requirements to address the cultural, linguistic and educational needs of the enrolled population. In the 1998/2000 contracts, plans were specifically required to comply with Title VI of the 1964 Civil Rights Act. This federal requirement prohibits recipients of federal funds from providing Limited English proficient persons with services that that are limited in scope or lower in quality than those provided to English proficient individuals. An individual's

participation in a federally funded program or activity may not be limited on the basis of Limited English proficiency.

In the 2000/2003 HFP plan contracts, MRMIB expanded its cultural and linguistic services requirements to include specific activities for providing linguistically and culturally appropriate services. These requirements were largely based on policies that the Department of Health Services implemented for the Medi-Cal Managed Care program. One key activity required by both Medi-Cal Managed Care, and subsequently Healthy Families, is for plans to conduct a Cultural and Linguistic Group Needs Assessment (GNA).

The HFP Group Needs Assessment requirement, which is based on the requirement used by the Department of Health Services for the Medi-Cal Managed Care Program, called for plans to examine certain characteristics of their HFP members, and to implement activities that would result in improved culturally and linguistically appropriate services.

Each HFP participating plan was required to conduct a GNA to identify the health risks, beliefs, and practices of their HFP subscribers. Each HFP plan was also required to develop work plans in response to identified health education, cultural and linguistic needs, including a timeline for implementing the work plan. The GNA and work plan were due to MRMIB on June 30, 2001.

In conducting the GNA, participating plans were to identify the following for their HFP subscribers:

- health-related behaviors and practices
- risk for disease, health problems, and conditions
- knowledge, attitudes, beliefs, and practices related to access and use of preventive care
- knowledge, attitudes, beliefs, and practices related to health risk
- perceived health, health care and health education needs and expectations
- cultural beliefs and practices related to alternative medicine
- perceived language needs and preferred methods of learning
- language needs and literacy level
- community resources and capability to provide health education and cultural and linguistic services

As was the case with Medi-Cal Managed Care, participating HFP plans were encouraged to use a variety of resources to gather information about their HFP subscribers. They were also required to provide opportunities for representatives of HFP subscribers to provide input on the GNA. In addition to identifying the health risks, beliefs and practices of subscribers, plans were required to develop health education programs in response to identified needs, with advice from representatives of subscribers.

Methodology for Conducting the Group Needs Assessment

Health plans that had conducted a GNA for Medi-Cal Managed Care were allowed to conduct the HFP GNA using the same methods used for the Medi-Cal Managed Care GNA. Some of these methods included using data from national, state and county agencies, obtaining information on health education and cultural and linguistic needs from community advisory committees, and surveys of plan providers. All participating plans were instructed to refer to the Medi-Cal Managed Care's GNA requirements for guidance. (The Medi-Cal Managed Care's GNA requirements were outlined in a policy letter, PL 99-02, which was sent to managed care plans participating in Medi-Cal Managed Care.) Plans that did not participate in Medi-Cal Managed Care were encouraged to collaborate with any HFP participating plan that serves Medi-Cal Managed Care. MRMIB staff shared sample outlines from a few Medi-Cal Managed Care GNAs with all plans to assist them in initiating their GNAs.

Participating HFP plans used a multitude of data sources for gathering information about the health related cultural and linguistic characteristics of ethnic and language groups represented in their HFP membership. The variety of data sources used for the HFP GNA was also seen in the Medi-Cal Managed Care Program.

Among the multitude of methods available to conduct the GNA, some methods were used by most plans and other methods were used by only a few plans. It appeared that most plans used two types of data sources; quantitative data from published sources or from claims and encounter data housed in the plan's internal data systems, and qualitative data from surveys, interviews or focus groups. With respect to quantitative data, the sources plans used included federal, state or county health data, HFP enrollment data, plan claims and encounter data, prevalence and incidence reports from published studies, and local needs assessment reports. Qualitative data was usually obtained from questionnaires or discussion guides developed by individual plans.

Quantitative Data

Plans obtained quantitative data on racial and ethnic health disparities, disease prevalence, mortality and morbidity rates and county demographic data (age and ethnic composition, languages spoken and income level) from federal, state and county sources (e.g., U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, California Department of Health Services, county public health departments, etc.). Plans used their claims and utilization data to gather information on the most common diagnoses and medications most frequently dispensed for their HFP subscribers. Plans also examined patterns of hospital admission by ethnicity and emergency room visits for HFP subscribers.

Many plans collected information from published reports on causes of health disparities among ethnic groups, access to care, cultural and linguistic barriers and the impact of health literacy. Sources of this information included studies prepared by national and state agencies and private philanthropic foundations. Examples of these reports include:

- The California Endowment and California Healthcare Foundation's *The Health Status of Latinos in California* (1992).
- The California Center for Health Improvement, the National Center for Education Statistics and the American Medical Association Foundation report on adult literacy competency and the impact of low literacy on health care issues (2000).
- The Dental Health Foundation's *Oral Health Needs Assessment of Children* (1993-1994).
- U.S. Department of Health and Human Services, National Standards on Culturally and Linguistically Appropriate Services in Health Care (December 2000).
- The Henry J. Kaiser Foundation report on the evidence of racial and ethnical health disparity in insurance coverage, access to primary care and treatment for specific medical conditions (1999).

Qualitative Data

In addition to quantitative data, a majority of plans used surveys, interviews and/or focus groups to obtain information directly from members, network providers and community based organizations (CBOs). The surveys assessed a variety of factors, including health education services utilized by members and providers, the top health education needs of subscribers, and services provided by the providers and community organizations. Other topics covered by the surveys included perceived barriers that impact access to care (such as mistrust of the health care system), preferred learning methods, top preventive and environmental health risks/concerns, the members' use of alternative medicines, language capability of providers and cultural sensitivity of the office staff.

Focus groups and interviews were conducted to supplement the external or survey data they obtained. Some plans gathered information from standing consumer committees, community advisory boards, or public policy committees comprised of members/parents, providers, and community advocates. One health

plan conducted a focus group comprised of adolescents, ages 14 to 18, on adolescent health care habits, health related topics they are interested in and health education materials they would like to receive.

In addition to the surveys, focus groups and interviews designed to address specific issues related to the GNA, plans also used results of the HFP Consumer Survey of Health Plans and their HFP Health Plan Quality Report to evaluate members' ability to access health care as well as their satisfaction with the services received.

Plan Activities to Address Identified Needs

Each participating plan identified several activities that it would implement to address the needs identified in the GNA. Most of the activities included education programs for subscribers, plan staff or network providers. Other types of activities target an aspect of a plan's infrastructure (e.g., modifying current information systems to improve tracking of cultural and linguistic needs of members).

Findings Summary

The findings that plans made in their GNA report can be generalized into five major areas. These areas and the types of activities plans proposed to address them are outlined below.

Finding 1 ►

Similarities exist among health and dental risks reported in national, state and local studies, health risks identified in claims and encounter data, and health, dental and vision education topics desired by HFP subscribers.

Most plans reviewed published reports to determine the health risks among children in general and children from various ethnic backgrounds. The data reported by plans showed that:

- Type II diabetes mellitus during childhood is the third most prevalent disease affecting all Native American tribes Latinos are 2.2 times more likely and African Americans are 2 times more likely to develop diabetes than Caucasians
- More African American children and adolescents are overweight when compared to that of Caucasian children and adolescents. It is suspected that this may be due to higher caloric intake and less physical activity
- African Americans have a 6 times higher rate of asthma hospitalizations than Caucasians
- California ranked 40th in the nation in the percentage of children who are adequately immunized

- Only 43 percent of Latino children in California have completed their immunization series by age 2
- Half of all children will have at least one episode of an ear infection by one year of age, and 35 percent of these will have a repeat episode
- Children in low-income families, who are usually members of racial and ethnic minority groups, are particularly vulnerable to dental disease
- Oral disease is commonly cited as the most widespread health problem nationwide particularly among children

In addition to data from published reports, plans reported data from an analysis of their administrative files. Health plans indicated that asthma, allergies, upper respiratory infections, and ear infections and/or ear pain, were the most common diagnoses among their HFP subscribers. A few health plans reported that asthma is one of the most frequent reasons for emergency room visits among HFP subscribers. Other plans reported that their pharmacy data shows that upper respiratory infections, including ear pain and/or ear infection, constitutes the number one disease category for total cost of prescriptions among their HFP subscribers.

Member surveys conducted by a few plans showed that families are interested in health education topics that address dental health, eye care for their families, and the prevalence of asthma, diabetes, etc. Specific topics of interest include:

- Diabetes/weight management/nutrition
- Asthma
- Safety and injury prevention
- Exercise and sports for children
- Oral health
- Preventive eye care and symptoms of eye problems

Provider surveys conducted by a few plans found that education on well child care, antibiotics use, smoking prevention/cessation and substance abuse were also important topics for HFP subscribers.

Action Steps ►

In response to these findings, plans identified several activities that will target educational efforts in these areas. Examples of these include:

<u>Diabetes/weight control</u>

- Implementing an Obesity/Type II Diabetes education and prevention program
- Developing a childhood obesity educational campaign

- Creating a committee of professionals working with children and adolescents to create a brochure listing all resources for nutrition, weight management and exercise programs that are available in the community
- Distributing a provider update bulletin to all plan HFP providers on how to access health education materials on nutrition, injury prevention, and other important health issues

Asthma education

- Asthma education program
- Searching for effective asthma intervention and management strategies

Safety and injury prevention

- Providing a bicycle safety education course for members with efforts made to either purchase or have donated helmets to distribute during events
- Implementing a car seat distribution program
- Promoting the importance of injury prevention among HFP members through newsletters

Preventive care

- Providing health education information and resources to HFP providers about immunizations and to improve immunization rates of children 2 years and younger
- Promoting the importance of childhood immunization through member newsletters
- Implementing a quality improvement program to increase immunizations and well-child visits screening rates among plan subscribers
- Raising awareness of the importance of preventive health visits among adolescents
- Promoting incentives for well-care visits
- Developing a brochure on the importance of well-child and well-adolescent care visits among HFP through member mailings
- Increasing the number of initial exams and preventive

Infection control

- Implementing an ear infection education campaign
- Implementing an antibiotic education campaign

Oral Health

- Developing appropriate oral hygiene brochures that explain the danger of dental caries and the importance of dental visits
- Disseminating dental health information to members through member newsletters, on plan websites, and including information in the “on-hold” messages in the phone system

Eye Care

- Creating health education materials that explain the importance of annual eye examinations and provide general information about common eye disorders for children

Finding 2 ►

Subscribers may not fully understand how to access plan services and their rights under the HFP.

Survey results from members, providers and CBOs indicated that members:

- Lacked knowledge of the managed care system and awareness of what benefits are available, and knowledge on how to use the plan
- Believed that the health care system is indifferent and a determining factor in health care delivery
- Were skeptical about using their health plan because of historic lack of access to care and poor outcomes
- Feared deportation or denial of citizenship might create a barrier to utilization of health care services

Action Steps ►

Examples of plan activities to increase subscriber's knowledge of the managed care system and member rights include:

- Providing members with culturally and linguistically appropriate education to promote their understanding of managed care plan services, health care benefits, and members' rights and responsibilities
- Exploring different ways to educate members on how to navigate and use the health care system
- Providing more information to help members understand their benefits
- Providing guidelines to members/subscribers through plan newsletter on the appropriate use of emergency room
- Collaborating with the Member Service Department to improve the benefit information given to members
- Hosting a HFP forum to give consumers, advocates and providers the opportunity to discuss their ideas, concerns and support for the HFP with their legislators and government officers, and to clarify misunderstandings and issues of concerns including the issue of public charge
- Developing resource guides that address the fear of government authority, especially among non-English speaking potential HFP members

Finding 3 ►

Differences in languages spoken between providers and HFP subscribers must be addressed

Plans must be able to communicate with subscribers/members in their preferred language. Based on results from surveys conducted with subscribers, providers and CBOs, several plans reported that:

- Members prefer to read educational materials in their primary language
- Literature and videos on health education should be made available in members' preferred languages
- Forms should be made easier to read and to complete
- Provider training is needed on health literacy and how to work with low-literacy patients

Several plans also indicated that most providers:

- Are aware that linguistic differences can present a barrier to health care for patients
- Believe that a very important factor to patients when seeking care is finding a provider who speaks their language and who is culturally sensitive
- Are interested in training for bilingual staff on medical interpretation

Action Steps ►

A large number of plans have identified activities that they will implement to improve their infrastructure so that it is responsive to members' linguistic health services need. Examples of these activities are:

- Developing a language certification services program for bilingual staff
- Maintaining an information system capable of identifying and profiling cultural and linguistic specific patient data
- Developing and maintaining linguistic standards and training, including supporting providers in maintaining the plan's linguistic standards
- Assessing the linguistic appropriateness of systems such as appeals and grievances, appointment and scheduling
- Developing a library for linguistic related reports
- Better informing providers of the availability of several options to assist providers with their limited-English speaking members
- Providing training to providers and office staff on how to work with medical interpreters
- Ensuring that plan providers have access to appropriate health education materials and linguistic resources

- Ensuring that the contractually required translations are made by maintaining and tracking data on language of HFP members
- Developing a communication and information program that is effective and sensitive to the multilingual subscribers of the plan
- Developing ongoing strategies for member's education on accessing linguistic services through the Evidence of Coverage (EOC), and member newsletters
- Assessing the cost and logistical requirements to produce HFP information materials in languages other than the acknowledged threshold languages to assist members on how to use plan services and make the plan a more desirable choice among other HFP participating plans in the community
- Continuing to monitor the linguistic capabilities of the plan's provider network to assure access to linguistically appropriate services throughout the plan's contracted service areas
- Evaluating the best method for providing health education materials to network providers in each of the plan's threshold languages, and ensuring that every network provider office displays translated, written educational materials in a visible location

Finding 4 ►

Providers need training to increase their cultural competency skills.

The HFP contract encourages participating plans to develop internal systems that meet the cultural needs of the plans' HFP subscribers. Examples of these internal systems are assessing the cultural competence of plan providers on a regular basis, and evaluating the need for special initiatives related to cultural competency.

Reports from several plans identified the following needs:

- Training of providers on cultural competency and awareness
- Training of front office staff on treating clients with more respect
- Educating members to communicate their use of traditional healing
- Expansion of quality improvement programs (QIP) to include practices to providers so providers can better serve their

needs a routine analysis of the quality of health care services provided to members and whether there are disparities in health outcomes

Several plans also indicated that most providers:

- Are aware that cultural differences can present a barrier to health care for patients
- Believe that a very important factor to patients when seeking care is finding a provider who is culturally sensitive
- Are interested in cultural competency education and cultural sensitivity for office staff
- Recognize that knowing about patients' cultural beliefs and practices related to health care, lifestyle and religious beliefs would help them to better serve patients

Results from plan surveys conducted of subscribers, providers and CBOs revealed that:

- Members want a culturally sensitive health care environment that is understanding and respectful of differences
- Members want providers who share their culture

Action Steps ►

A large number of plans have identified activities that they will implement to improve their infrastructure so that it is responsive to their member's cultural and linguistic health services need. Examples of these activities are:

- Providing initial and continuing training on cultural competency to staff
- Developing recruitment and retention initiatives to establish organization-wide staffing that is reflective and responsive to the needs of the community
- Maintaining an information system capable of identifying and profiling cultural specific patient data
- Incorporating cultural services in plan's mission statement
- Developing and maintaining cultural standards and training, including diversity training and supporting providers in maintaining plan's cultural standards
- Implementing a program to increase awareness and cultural competency and sensitivity in health care delivery among the staff, administrators and providers in the network
- Assessing the cultural and appropriateness of systems such as appeals, grievances, and appointment and scheduling
- Developing a library for cultural related reports

- Sharing with plan providers what the plan has learned about the cultural beliefs and practices of the plan's population and continue to educate providers on different ethnic group's view of health and healing and providing helpful strategies for working with these differences
- Increasing members' and providers' access to culturally appropriate health education materials

Finding 5►

Community-Based Organizations (CBOs) can assist plans in providing culturally and linguistically appropriate services

Plans report that information gathered from the members and providers, as well as teen focus groups indicate that:

- Providers, CBOs and family members play important roles in promoting and advocating health issues among certain ethnic groups
- There is a greater need for advertising and promotion of community resources
- Relationships between the plans and CBOs should be strengthened
- Plans can benefit from information received from member focus groups such as those specifically designed to address issues relevant to their teen members

Action Steps ►

A large number of the plans' GNAs contain action steps related to actively involving plan members, plan providers, and the community in the development and provision of culturally and linguistically appropriate health services. Some of the collaborative initiatives to be undertaken include:

- Maintaining on-going functioning committees (e.g., Advisory and/or Public Policy) with member and community representatives. One plan will be diversifying its Advisory Committee to include more CBOs and threshold language populations. Another plan is exploring the feasibility of establishing a Youth Advisory Committee to better understand issues that youth face and to provide them with an opportunity to provide input directly to the plan. Another activity is to continue the provision of resources to when to make referrals to community services
- Conducting member surveys and focus groups to solicit consumer information and to identify the needs and opinions of a broad representation of ethnic groups

- Developing a link between the county public health department and the plan to coordinate education and outreach resources
- Continuing participation in the county health services cultural and linguistic committees which advise plans on cultural and linguistic issues, training, access and recruitment of qualified bilingual, bicultural staff
- Establishing effective partnering strategies with CBOs to investigate identified cultural barriers to patient care and sharing resources which are culturally competent for member health education and other services to members
- Establishing CBO contracts for outreach to communities such as the African American and Cambodian communities
- Providing health education in the communities where members reside through community outreach programs and collaborating and sharing resources with CBOs

Conclusion

The GNA requirement resulted in plans focusing their efforts on developing culturally and linguistically appropriate services for their subscribers in key areas. Many plans reported that the GNA helped them prioritize their health education services and resulted in the development of plan-wide activities to address structural issues that are important to meet the cultural and linguistic needs of their subscribers. The GNAs also uncovered weaknesses in current practices for providing linguistically appropriate services (e.g., free interpreter services). Finally, the GNAs have resulted in some plans initiating collaborative relationships with CBOs and advocates to provide culturally and linguistically appropriate services.

The variety of activities that plans will implement to address the needs identified in the GNA provide an opportunity to observe which activities are most successful in providing culturally and linguistically appropriate care. Since a standard set of activities for addressing cultural and linguistic needs for various ethnic populations does not exist, participating plans will be experimenting with various ideas and methods. Through this experimentation, participating plans and MRMIB will discover best practices for providing culturally and linguistically appropriate services that can be shared with all plans and result in program-wide enhancements in the provision of culturally and linguistically appropriate services. Next year, MRMIB will be able to assess the progress plans are making in implementing these activities through the annual Cultural and Linguistic Services Report. This report provides MRMIB with

descriptions of how plans will provide culturally and linguistically appropriate services for the upcoming benefit year.

Future Considerations

No broadly accepted standard exists in California or elsewhere for conducting GNAs or for developing activities to meet the needs identified. As a result, HFP participating plans have submitted different results and work plans which allow MRMIB to observe the success of the various activities implemented by participating plans

The GNA requirement for the Medi-Cal Managed Care Program and the HFP was a new concept for plans participating in these programs. Although Medi-Cal and/or HFP participating plans were required to comply with Title VI of the Civil Rights Act of 1964, the GNA requirements pushed each plan to examine the demographic diversity and unique health-related needs present within the plan's membership. The Department of Health Services was the State's and nation's pioneer in developing specific standards for plans to undertake to respond to the cultural and linguistic needs of their subscribers. The HFP requirements are modeled on this groundbreaking work of the Department of Health Services, which occurred three years ago. Given that conducting GNAs is a new requirement for participating plans, little information is available about the effectiveness of GNAs in expanding access to culturally and linguistically appropriate services provided by participating plans.

Assembly member Wilma Chan introduced AB 2739 that would codify the cultural and linguistic requirements that currently exists in the HFP contracts. Included in the bill is a requirement that plans conduct a GNA every three years. At the request of MRMIB staff, the sponsors of the bill indicated they were willing to extend the periodicity of the GNA requirement in the bill, but were unable to submit changes to Assembly member Chan's office before the deadline. The bill's sponsors have committed to pursuing clean-up legislation that would require GNAs to be conducted every five years or when there is a material change in the demographic mix of a plan's HFP enrollment. The sponsors have also agreed to give MRMIB more flexibility in determining the elements of the GNA based on new developments in the field and advice from experts in the provision of cultural and linguistically appropriate services, health education, and experts in conducting needs assessments. On August 30, 2002, the bill was passed by the Senate and was sent to the Governor for signature.

For future GNAs to be useful, it will be necessary for MRMIB to address a few lessons that were learned from this first round of GNAs. First, the wide range of GNA results and work plans will provide an opportunity to identify best practices. However, once best practices are identified, MRMIB will need to consider how it

might reflect these best practices in the contract requirements for the GNA. Examples of how this might be addressed may be for plans to further evaluate the effectiveness of a particular best practice, or provide a timeline for implementing a particular best practice.

Second, a broader collaboration among health plans requires leadership by MRMIB staff. Although plans were encouraged to work together to conduct their GNAs, only a few plans collaborated with one another and the collaboration was only focused on one aspect of the GNA. Since plans reported that conducting a GNA requires significant staff resources, the leverage of resources across all plans to conduct a more comprehensive GNA did not occur. For future GNA requirements, MRMIB staff will form a collaborative with participating HFP plans and the Medi-Cal Managed Care Program to identify ways for plans to conduct their GNAs more efficiently.

As a final note, MRMIB staff will hold discussions with individuals who have expertise in the area of health education, needs assessment and cultural and linguistic services to ensure that the GNA requirements reflect the latest thinking in the field. Since the federal Office of Minority Health has issued specific guidelines for providing culturally and linguistically appropriate services, it is expected that health plans and public programs around the country will be developing methods for implementing these guidelines. To date there have been several national and statewide conferences on the topic. Through these formal venues, the GNA requirements will be kept current in methodology and relevant to the populations being served.